February 14, 2003

MDR Tracking #: M2-03-0344-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Physical Medicine and Rehabilitation. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ is a 49-year-old gentleman who fell backward when he was attempting to unload an 18-wheeler, landing on is left elbow and his right hip. He had immediate numbness and pain in the left forearm and pain in the lumbar area and in the left buttocks and lateral thigh. The discomfort was described as a burning feeling. He was seen by ___ who took him off work and prescribed nati-inflammatories, pain medications and muscle relaxers. He continued to have symptoms. A lumbar MRI one on 8/5/02 identified an L4/5 large bulging disc and congenital stenosis and osteoarthritis facets. Physical therapy was recommended as well as an intramuscular stimulator. When he saw ___ on follow-up, he reported having improvement or relief of pain with the intramuscular stimulator after it had been used on a trial basis. His treating doctor recommended the purchase of the stimulator. The carrier responded with no authorization for the recommended services.

REQUESTED SERVICE

___ treating doctor has recommended the purchase of a neuromuscular stimulator.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The use of the Stat 2000 device to control the pain is appropriate and medically necessary for this patient. Though the use of neuromuscular stimulating devices and other E-stim devices have been controversial in the medical literature, ___has demonstrated a clinical response to the unit with decreased pain, a response that takes precedence over the controversies in medical literature.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of___, dba ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).